MONTANA CHEMICAL DEPENDENCY CENTER POLICY AND PROCEDURE MANUAL

Policy Subject: Documentation	
Policy Number: MRP 07	**Standards/Statutes: ARM 37.27.120**
Effective Date: 01/01/02	**Page 1 of 2**

PURPOSE: To outline the basic rules of quality documentation.

POLICY: To ensure proper record keeping, staff must have a working knowledge of the rules regarding documentation. Proper record keeping provides quality care and is one of the most important ways to avoid liability. A patient record must:

a. Contain sufficient data,
b. Be written in a sequence of events,
c. Justify the diagnosis,
d. Warrant the treatment and outcomes.

PROCEDURE:
Enter information fully and completely. Describe all significant information fully. Remember, if it is not documented in the chart, it did not happen.

Enter information in a factual and objective manner. All statements in a record should be based on facts, concrete observations, or the patient's own statements. If you are documenting information that is a patient's self report, i.e. an incident, condition, symptoms, etc., preface the information with according to the patient's report.

Avoid vague and subjective documentation. Be specific, document by your senses (by what you see, hear, smell, and/or touch).

Enter information in a patient record promptly. Block charting, i.e. 0700 to 1100, 1500 to 2200, should be avoided.

Late entries: if the note you are charting happened at an earlier time, record the time and date the note is being entered into the chart, label the entry "Late Entry" and complete the note.

The majority of documentation is completed on TIER. If documentation is completed by hand, write neatly, legibly and in black ink.
Use only facility-approved abbreviation and symbols.

Date and time all entries and sign with first initial, last name and professional identification.

Avoid grammatical and spelling errors.

To correct documentation that is a mistake, draw a single line through the error, date and initial the error, then immediately record the correct data. If a note is mistakenly documented in TIER on the wrong patient chart, the staff that made the error needs to make an addendum in the incorrect chart, stating the note dated on such and such a date is erroneous due to being in the incorrect chart. When the hard copy of the chart is printed at the time of discharge, the staff will need to draw a single line through the error, followed by the date and signature.

A chart should be free of erasures and any other kind of alteration. Writing over an incorrect number, scribbling out a mistake, adding forgotten information to the margin of a progress note, squeezing a note in between the lines of an existing note are examples of improper charting procedure.

At the end of a page, sign the note with first initial, last name, professional credentials and include date and time. If the note is continued on the next page, this should be indicated at the bottom of the page. Make sure the new page has the proper patient identification, and the note should be labeled continued. The continued note should be again dated and timed.

Never skip lines between entries, never leave blank lines for other shifts to fill in later.

Nursing is responsible to make sure the chart is clearly labeled for allergies. The locations for allergies are the standing orders, the Medication Administration Record, the top of the Doctor's Order Sheet, the cardex, and the outside of the patient's chart. At the time of admission, nursing also notifies the kitchen of any food-related allergy.

All patient education should be documented in the progress notes.

All boxes or spaces in a flow sheet need to be filled in. If the box is not applicable to that particular patient or that particular time, N/A needs to be indicated.

Any phone conversation regarding the patient, i.e. with an other health care provider, DFS worker, judge, probation officer, etc., needs to be documented in the patient chart.

Revisions:

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